APPENDIX F

FORMS

OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT
PATIENT DISCHARGE DATA PROGRAM
MANUAL ABSTRACT REPORTING FORM

For use with discharges on or after January 1, 2000

Instructions: For a description of the data elements, refer to the appropriate section of Discharge Data Regulations (Sections 97210 through 97239, Title 22, California Code of Regulations).

1. TYPE OF CARE

1 Acute
3 SN/IC
4 Psychiatric
5 Chem Dep
6 Physical Rehab

1a. HOSPITAL ID NUMBER

17. ABSTRACT RECORD NUMBER (Optional)

2. DATE OF BIRTH

Month | Day | Year (4 - Digit)

20. PATIENT'S SOCIAL SECURITY NUMBER

(000 00 0001 If not recorded in the medical record)

3. SEX

1 Male
2 Female
3 Other
4 Unknown

4. RACE

ETHNICITY
1 Hispanic
2 Non-Hispanic
3 Unknown

RACE
1 White
2 Black
3 Native American/ Eskimo/Aleut
4 Asian/Pacific Islander
5 Other
6 Unknown

5. ZIP CODE

6. ADMISSION DATE

Month | Day | Year (4 - Digit)

9. DISCHARGE DATE

Month | Day | Year (4 - Digit)

16. TOTAL CHARGES

(Report whole dollars only, right justified)

7. SOURCE OF ADMISSION

SITE
1 Home
2 Residential Care Facility
3 Ambulatory Surgery
4 SN/IC
5 Acute Inpatient Hospital Care
6 Other Inpatient Hospital Care
7 Newborn
8 Prison/Jail
9 Other

LICENSURE OF SITE
1 This Hospital
2 Another Hospital
3 Not a Hospital

ROUTE
1 Your ER
2 Not Your ER (or no ER)

8. TYPE OF ADMISSION

1 Scheduled
2 Unscheduled
3 Infant, under 24 hrs old
4 Unknown

15. EXPECTED SOURCE OF PAYMENT

PAYER CATEGORY
01 Medicare
02 Medi-Cal
03 Private Coverage
04 Workers' Compensation
05 County Indigent Programs
06 Other Government
07 Other Indigent
08 Self Pay
09 Other Payer

TYPE OF COVERAGE
1 Managed Care - Knox - Keene/ MCOHS
2 Managed Care - Other
3 Traditional Coverage

NAME OF PLAN

(0001 - 9999 Plan Number)

14. DISPOSITION OF PATIENT

01 Routine (Home)
Within This Hospital
02 Acute Care
03 Other Care
04 SN/IC
To Another Hospital
05 Acute Care
06 Other Care (Not SN/IC)
07 SN/IC
08 Residential Care Facility
09 Prison/Jail
10 Against Medical Advice
11 Died
12 Home Health Service
13 Other

21. PREHOSPITAL CARE AND RESUSCITATION

DNR order written at the time of or within the first 24 hrs of admission

Y = Yes
N = No

E - CODES

18. PRINCIPAL E

19. OTHER E E E E

Be sure page 2 is copied on the reverse side!

OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT
PATIENT DISCHARGE DATA PROGRAM
SUPPLEMENTAL REPORTING PAGE

For use with discharges on or after January 1, 2000

10. PRINCIPAL DIAGNOSIS

CODE

10a. PRESENT AT ADMISSION

Y = Yes
N = No
U = Uncertain

11. OTHER DIAGNOSES

11a. PRESENT AT ADMISSION

a.		a.
b.		b.
c.		c.
d.		d.
e.		e.
f.		f.
g.		g.
h.		h.
i.		i.
j.		j.
k.		k.
l.		l.
m.		m.
n.		n.
o.		o.
p.		p.
q.		q.
r.		r.
s.		s.
t.		t.
u.		u.
v.		v.
w.		w.
x.		x.

Y = Yes
N = No
U = Uncertain

12. PRINCIPAL PROCEDURE

CODE

DATE

Month | Day | Year (4 - Digit)

13. OTHER PROCEDURES

a.		a.
b.		b.
c.		c.
d.		d.
e.		e.
f.		f.
g.		g.
h.		h.
i.		i.
j.		j.
k.		k.
l.		l.
m.		m.
n.		n.
o.		o.
p.		p.
q.		q.
r.		r.
s.		s.
t.		t.

Month | Day | *Year (4 - Digit)*

Be sure page 1 is copied on the reverse side!

OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT

PATIENT DISCHARGE DATA

INDIVIDUAL HOSPITAL TRANSMITTAL FORM

OSHPD Use Only
PM Date: _____
Batch: _____
Agent: _____

Hospital Name: _____

Hospital Identification Number: | | | | | | |

Report Period From: _____ to _____

Total Number of Records: _____

MAGNETIC TAPE

( ) 9 track, 1,600 BPI ( ) 9 track, 6,250 BPI

( ) IBM Standard Labels ( ) Unlabeled

( ) EBCDIC ( ) ASCII

( ) IBM 3480 Compatible Cartridge

BLOCK SIZE: _____

DISKETTE

( ) 5¼" Diskette

( ) 3½" Diskette

( ) CD-ROM

Filename:

_____

CERTIFICATION

I, _____, certify under penalty of perjury as follows:
(Name of Individual)

That I am an official of _____ and am duly authorized to sign
(Name of Hospital)

this certification; and that, to the extent of my knowledge and information, the accompanying discharge abstract data records are true and correct, and that the definitions of the data elements required by Subdivision (g) of Section 128735 of the Health and Safety Code, as set forth in the California Code of Regulations, have been followed by this hospital.

Dated: _____ By: _____
(Signature)

Hospital: _____ Name: _____
(Please Print)

Address: _____ Title: _____

_____ Phone: _____

OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT

PATIENT DISCHARGE DATA

AGENT'S TRANSMITTAL FORM

OSHPD Use Only

PM Date: _____

Batch: _____

Agent: _____

Agent's Name: _____

Contact Person: _____ Title: _____

Address: _____

Phone No: ( ) _____ Ext: _____

MAGNETIC TAPE

( ) 9 track, 1,600 BPI ( ) 9 track, 6,250 BPI

( ) IBM Standard Labels ( ) Unlabeled

( ) EBCDIC ( ) ASCII

( ) IBM 3480 Compatible Cartridge

BLOCK SIZE: _____

DISKETTE

( ) 5¼" Diskette

( ) 3½ Diskette

( ) CD-ROM

Filename:

_____

	HOSPITAL NAME	HOSP IDENT NO	REPORT PERIOD BEGINNING	REPORT PERIOD ENDING	TOTAL NO OF RECORDS
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					

OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT
PATIENT DISCHARGE DATA

DISCHARGE DATA CERTIFICATION FORM

I, _____, certify under penalty of perjury as follows:
(Name of Individual)

That I am an official of _____ and am duly authorized to
(Name of Hospital)

sign this certification; and that, to the extent of my knowledge and information, the discharge abstract data records submitted to _____ for the period
(Name of My Hospital's Designated Agent)

from _____ to _____ are true and correct, and that the definitions
(Starting Date) (Ending Date)

of the data elements required by Subdivision (g) of Section 128735 of the Health and Safety Code, as set forth in the California Code of Regulations, have been followed by this hospital.

Dated:_____

_____
(Name of Hospital)

Hospital Identification No: | | | | | | |

Name: _____
(Signature)

Name: _____
(Please Print)

Title: _____

Address: _____

_____

Phone: _____

DISCHARGE DATA DISCLOSURE REPORTING
EXTENSION REQUEST

To: Office of Statewide Health Planning and Development
Healthcare Information Division
818 K Street, Room 100
Sacramento, CA 95814
(916) 323-7679
Fax No. (916) 322-9555
Fax No. (916) 327-1262

Date: _____

ATTN: Patient Discharge Data Section

1. Hospital Name (DBA): _____
2. Address: _____
3. Mailing Address (if different): _____
4. Hospital Identification Number: _____
5. Report Period Beginning Date: _____
6. Report Period Ending Date: _____
7. Designated Agent (if applicable): _____
8. Number of Days of Extension Request: _____
9. Justification: (Include actions taken to produce the data by the required deadline, and factors that prevent submission of the data by the deadline, and actions to be taken and the time needed to accommodate them):

_____

_____

_____

_____

_____

_____

10. Person Requesting Extension (print): _____
11. Signature: _____
12. Title: _____
13. Phone: _____